



106TH CONGRESS
1ST SESSION

H.R. 298

To improve health status in medically disadvantaged communities through comprehensive community-based managed care programs.

IN THE HOUSE OF REPRESENTATIVES

JANUARY 6, 1999

Mr. TOWNS introduced the following bill; which was referred to the Committee on Commerce

A BILL

To improve health status in medically disadvantaged communities through comprehensive community-based managed care programs.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the "Comprehensive Health
5 Access District Act".

6 **SEC. 2. DEFINITIONS.**

7 (a) COMPREHENSIVE HEALTH ACCESS DISTRICT.—
8 The term "comprehensive health access district" means
9 a community in which unemployment and the percentage
10 of residents with incomes below the poverty line are great-

1 er than the national average, and in which a majority of
2 the following conditions occur at rates greater than the
3 national average:

4 (1) Infant mortality and low birth-weight ba-
5 bies.

6 (2) Proportion of children below the age of 5
7 who have not received age-appropriate routine child-
8 hood immunizations.

9 (3) Hospitalization for preventable illnesses and
10 conditions that may be managed successfully on an
11 outpatient basis, such as otitis media, diabetes, and
12 hypertension.

13 (4) Emergency room visits for nonemergency
14 conditions.

15 (5) Accidental injury.

16 (6) Incidence of tuberculosis, acquired immune
17 deficiency syndrome, Black Lung disease, or cancer.

18 (7) Incidence of violent crimes.

19 (b) COMPREHENSIVE COMMUNITY-BASED HEALTH
20 ACCESS PLAN.—The term “comprehensive community-
21 based health access plan” (hereafter in this Act referred
22 to as a “health access plan”) means an entity that pro-
23 vides health care services on a prepaid, capitated basis or
24 any other risk basis and that the Secretary has certified
25 meets the requirements contained in section 5 of this Act.

1 (c) SECRETARY.—The term “Secretary” means the
2 Secretary of Health and Human Services.

3 **SEC. 3. MEDICAID STATE PLAN REQUIREMENTS FOR COM-**
4 **PREHENSIVE HEALTH ACCESS DISTRICTS.**

5 Section 1902(a) of the Social Security Act (42 U.S.C.
6 1396a(a)) is amended by adding after paragraph (62) the
7 following new paragraph:

8 “(63) provide that each comprehensive health
9 access district located within the State is served by
10 a comprehensive community-based health access dis-
11 trict plan.”

12 **SEC. 4. HEALTH ALLIANCE OBLIGATIONS WITH RESPECT**
13 **TO COMPREHENSIVE HEALTH ACCESS DIS-**
14 **TRICTS.**

15 Each Health Alliance or other health insurance pur-
16 chasing cooperative created as a result of the enactment
17 of comprehensive health care reform legislation that re-
18 ceives premiums on behalf of persons formerly insured
19 under title XIX of the Social Security Act and whose
20 boundaries encompass a comprehensive health access dis-
21 trict shall insure that a least one comprehensive commu-
22 nity-based health access plan is available to persons living
23 in such district.

1 **SEC 5. COMPREHENSIVE COMMUNITY-BASED HEALTH AC-**
2 **CESS PLANS.**

3 To be certified as a comprehensive community-based
4 health access plan, an entity must meet all of the following
5 requirements:

6 (a) **ORGANIZATIONAL REQUIREMENTS.**—A health ac-
7 cess plan must—

8 (1) be a public or private organization,
9 organized under the laws of any State;

10 (2) locate its primary place of business in the
11 comprehensive health access district it serves;

12 (3) give preference in hiring to otherwise quali-
13 fied individuals who live within the comprehensive
14 health access district; and

15 (4) have made adequate provision against the
16 risk of insolvency, which provision is satisfactory to
17 the State and which assures that in individuals en-
18 rolled in a plan are in no case liable for debt of the
19 plan in case of the plan's insolvency. Provisions
20 against the risk of insolvency may include—

21 (A) escrow or similar arrangements to en-
22 sure that funds for the payment of providers
23 are available only for such payments and can-
24 not be otherwise used by the plan;

1 (B) reinsurance purchased by the plan of
2 an amount which is reasonably adequate to in-
3 sure against unexpected costs;

4 (C) a demonstration of financial viability,
5 as evidenced by the plan's obtaining a signifi-
6 cant amount of reinsurance, line of credit, or
7 performance bond; or

8 (D) such other mechanisms and require-
9 ments as the State finds appropriate.

10 (b) SERVICE REQUIREMENTS.—

11 (1) BASIC BENEFITS.—A health access plan
12 shall provide, either directly or through arrange-
13 ments with providers, the following basic benefits:

14 (A) Hospital services, including inpatient,
15 outpatient and 24-hour emergency services.

16 (B) Emergency and ambulatory medical
17 and surgical services.

18 (C) Physicians' services.

19 (D) Medical care other than physicians'
20 services recognized under State law and fur-
21 nished by licensed practitioners within the scope
22 of their practice as defined by State law.

23 (E) Dental services.

24 (F) Vision services.

1 (G) Preventive health care services (includ-
2 ing children's eye and ear examinations to de-
3 termine the need for vision and hearing correc-
4 tion, well child services, immunizations against
5 vaccine-preventable diseases, and screening for
6 elevated blood lead levels).

7 (H) Outpatient laboratory, radiology, and
8 diagnostic services.

9 (I) Ambulance services.

10 (J) Mental health and substance abuse
11 services.

12 (K) Family planning services and services
13 for pregnant women.

14 (L) Outpatient prescription drugs and
15 biologicals.

16 (2) COMMUNITY-BASED HEALTH SERVICES.—In
17 addition to providing the services described in para-
18 graph (b)(1), a health access plan shall—

19 (A) identify the most frequent causes of
20 morbidity and mortality in the comprehensive
21 health access district (such as acquired immune
22 deficiency syndrome, tuberculosis, mental ill-
23 ness, substance abuse and addiction, childhood
24 developmental disorders (particularly those
25 caused by children's exposure to violence), asth-

ma, teen pregnancy, unhealthy behaviors (such as smoking and high-fat diets), and lead poisoning); and

(B) design and implement programs of prevention, early intervention, or treatment intended to ameliorate or eliminate the factors identified in subparagraph (b)(2)(A).

(3) COORDINATION OF SERVICES.—In addition to providing the services described in paragraphs (b)(1) and (b)(2), a health access plan must promote its enrollees' access to social, educational or economic services (such as child day care, nutritional services, vocational training, and adult literacy programs).

(c) SERVICE NETWORK REQUIREMENTS.—

(1) BASIC SERVICE NETWORK.—A health access plan shall enter into arrangements with a sufficient number and variety of providers to guarantee that—

(A) the plan's enrollees have access to the services described in subsection 4(b); and

(B) the provider network takes into account and is representative of the cultural identity and diversity of the community being served.

1 (2) TRADITIONAL COMMUNITY PROVIDERS.—A
2 health access plan shall, to the extent feasible, draw
3 upon health care providers currently serving the
4 community, including community health centers (as
5 defined in section 330(a) of the Public Health Serv-
6 ice Act) and hospitals operated by units of local gov-
7 ernment, in developing its service network.

8 (3) DEVELOPMENT OF NEW HEALTH RE-
9 SOURCES.—A health access plan shall develop new
10 health resources in the community (such as
11 schoolbased clinics, mobile screening programs, and
12 clinics based in public housing) to meet needs that
13 are not met by existing community resources.

14 (d) ACCESS STANDARDS.—A health access plan shall
15 insure that each individual enrolled in it—

16 (1) is linked with the primary care physician
17 within the health access plan's provider network of
18 the individual's choice and has access to that doctor
19 on a 24-hour a day, 7-day a week basis;

20 (2) has round-the-clock telephone access to a
21 central program office for information purposes as
22 well as to voice grievances; and

23 (3) has access to interpreter services as nec-
24 essary (where a significant proportion of the popu-
25 lation in the community health access district is non-

1 English speaking, the health access plan shall insure
2 that a corresponding proportion of its health care
3 providers have multilingual capability).

4 (e) QUALITY ASSURANCE STANDARDS.—A health ac-
5 cess plan shall establish and maintain a quality assurance
6 program that includes at least the following activities:

7 (1) TREATMENT STANDARDS.—A health access
8 plan shall establish—

9 (A) minimum standards for treating pa-
10 tients that participating providers must satisfy;

11 (B) a program of ongoing medical record
12 reviews and other provider audits to insure
13 compliance with the plan's treatment standards;
14 and

15 (C) a system of sanctions to insure that
16 providers who do not comply with the plan's
17 treatment standards will be penalized and, if
18 found to be repeatedly out of compliance, termi-
19 nated from participation in the health access
20 plan service network.

21 (2) DATA COLLECTION.—A health access plan
22 shall monitor morbidity and mortality within the
23 comprehensive health access district and identify the
24 leading causes of death and disease.

1 (3) MEMBER SURVEYS.—A health access plan
2 shall survey its enrollees on a regular basis to deter-
3 mine their satisfaction with the quality of services
4 received.

5 (4) INDEPENDENT QUALITY AUDITS.—A health
6 access plan shall be evaluated on a regular basis by
7 an independent health care accrediting organization.

8 (f) EFFECTIVE GRIEVANCE PROCEDURES.—A health
9 access plan must provide for effective procedures for hear-
10 ing and resolving grievances between the plan and individ-
11 uals enrolled in the plan.

12 (g) CONFIDENTIALITY OF ENROLLEE RECORDS.—

13 (1) A health access plan shall ensure that infor-
14 mation concerning its enrollees is protected from un-
15 authorized disclosure by the plan, its employees or
16 its providers.

17 (2) To promote the coordination of benefits to
18 health plan enrollees, a health access plan may dis-
19 close information about its enrollees to the extent
20 necessary to facilitate the enrollee's receipt of serv-
21 ices and assistance from other entities.

1 **SEC. 6. DESIGNATION OF COMPREHENSIVE HEALTH AC-**
2 **CESS DISTRICTS AND CERTIFICATION OF**
3 **COMPREHENSIVE COMMUNITY-BASED**
4 **HEALTH ACCESS PLANS.**

5 The Secretary shall designate a community that
6 meets the criteria set forth in section 2(a) of this Act a
7 comprehensive health access district and shall certify an
8 entity that meets the criteria set forth in section 5 of this
9 Act as a comprehensive health access plan. Each such cer-
10 tification and designation shall be reviewed every five
11 years. The Secretary may delegate all or part of the cer-
12 tification function to the State in which the health access
13 plan operates.

14 **SEC. 7. NATIONAL HEALTH OUTCOMES RESEARCH AND**
15 **EVALUATION.**

16 (a) **PROVISION OF INFORMATION.**—In order to evalu-
17 ate the performance of health access plans in improving
18 the health status of persons living in comprehensive health
19 access districts, each health access plan shall provide the
20 Secretary, at a time and in a manner specified by the Sec-
21 retary, at least the following information:

22 (1) Information on the characteristics of enroll-
23 ees that may affect their need for or use of health
24 services.

25 (2) Information on the types of treatments and
26 services and outcomes of treatments with respect to

1 the clinical health, functional status and well-being
2 of enrollees.

3 (3) Information on enrollee satisfaction.

4 (4) Information on health care expenditures,
5 volume and prices of procedures, and use of special-
6 ized services.

7 (b) ANALYSIS OF INFORMATION.—The Secretary
8 shall analyze the information reported by health access
9 plans in order to report to Congress, the plans and the
10 public, no less than annually, on the following:

11 (1) The health status of persons living in com-
12 prehensive health access district (particularly those
13 indicators listed in section 2(a) of this Act).

14 (2) The level and rate of expenditures by health
15 access plans on medical services and other programs
16 to improve health status.

17 (3) The effectiveness of health access plans in
18 improving health outcomes (particularly outcomes
19 related to health indicators listed in section 2(a) of
20 this Act).

21 (c) RESEARCH.—

22 (1) The Secretary shall examine the relation-
23 ship between socioeconomic factors and health status
24 and, based on his findings, suggest interventions ap-
25 propriate to comprehensive health access districts.

1 (2) The Secretary may contract with non-gov-
2 ernmental entities to perform this research. Persons
3 undertaking this work shall have access to the infor-
4 mation provided by the health access plans to the
5 Secretary.

6 **SEC. 8. REGULATIONS AND EFFECTIVE DATE.**

7 (a) The Secretary shall promulgate regulations nec-
8 essary to implement this Act.

9 (b) This Act shall take effect on July 1, 1999, with-
10 out regard to whether or not final regulations to carry out
11 this Act have been promulgated by such date.

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